SERFF Tracking Number:	*MWSG-125760358*	*State:*	*Arkansas*
Filing Company:	*Western Reserve Life Assurance Co. of Ohio*	*State Tracking Number:*	*39867*
Company Tracking Number:	*U000310*		
TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*Informational Filing Related to Previously Approved Application U000310*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Western Reserve Life Assurance Co. of Ohio

Product Name: Informational Filing Related to Previously Approved Application U000310	SERFF Tr Num: MWSG-125760358	State: ArkansasLH
TOI: L09I Individual Life - Flexible Premium Adjustable Life	SERFF Status: Closed	State Tr Num: 39867
Sub-TOI: L09I.001 Single Life	Co Tr Num: U000310	State Status: Filed-Closed
Filing Type: Form	Co Status:	Reviewer(s): Linda Bird
	Authors: June Stracener, Dorothy Seals	Disposition Date: 08/15/2008
	Date Submitted: 08/06/2008	Disposition Status: Accepted For Informational Purposes
Implementation Date Requested: 09/15/2008		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Informational	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 08/15/2008	
State Status Changed: 08/15/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

On behalf of our client, Western Reserve Life Assurance Co. of Ohio (the "Company"), we are submitting this INFORMATIONAL FILING which revises information surrounding the use of life application form U000310 . Your Department approved this form on August 31, 2007, and a copy is included in this filing for your reference. Please note that the Company has not revised this form in any way. The Company intends to continue using the form in a traditional

manner whereby the Owner/Applicant signs the application in ink and physically submits the application to the Company.

The Company now also plans to make this form available electronically. It is the Company's intent to use this form in a variety of electronic environments, including a laptop and web based application process. Regardless of the application process used, the Company intends to adopt measures to secure both the integrity of the document once signed, and the confidentiality of any information transmitted, including transmission of the information via a secured socket layer/secured line. The information contained in the application will be transmitted to the Company's administrative office electronically as well as the electronic signature of the Owner/Applicant. Current technology will be used to ensure that the confidential information is not comprised. All processes used will comply with the Uniform Electronic Transactions Act, and to the extent applicable, the Federal E-SIGN Act.

The Company certifies that any electronic signature it obtains will be linked to the date on the electronic application in such a manner that the electronic signature is invalidated if any of the data on the application is changed. The Company also certifies that such electronic signature intended for use with this application will not be affixed to or duplicated on any other document.

The Company intends to implement this use of the application on September 15, 2008. A copy of the application, identical to the filed form, will be printed and made part of any policy issued. Ohio is this Company's state of domicile.

Company and Contact

Filing Contact Information

(This filing was made by a third party - MWSGW01)

Doak Foster, Attorney
425 West Capitol Avenue
Little Rock, AR 72201-3525
dfoster@mwsgw.com
(501) 688-8841 [Phone]
(501) 688-8807[FAX]

Filing Company Information

Western Reserve Life Assurance Co. of Ohio	CoCode: 91413	State of Domicile: Ohio
4333 Edgewood Road	Group Code: 468	Company Type: Life Insurer
Cedar Rapids, IA 52499	Group Name: AEGON USA Inc.	State ID Number:
(319) 355-8511 ext. [Phone]	FEIN Number: 43-1162657	

SERFF Tracking Number:	*MWSG-125760358*	*State:*	*Arkansas*
Filing Company:	*Western Reserve Life Assurance Co. of Ohio*	*State Tracking Number:*	*39867*
Company Tracking Number:	*U000310*		
TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*Informational Filing Related to Previously Approved Application U000310*		
Project Name/Number:	*/*		

SERFF Tracking Number:	*MWSG-125760358*	*State:*	*Arkansas*
Filing Company:	*Western Reserve Life Assurance Co. of Ohio*	*State Tracking Number:*	*39867*
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Product Name:	*Informational Filing Related to Previously Approved Application U000310*		
Project Name/Number:	*/*		

Filing Fees

Fee Required?	No
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Western Reserve Life Assurance Co. of Ohio	$0.00	08/06/2008	

SERFF Tracking Number:	*MWSG-125760358*	*State:*	*Arkansas*
Filing Company:	*Western Reserve Life Assurance Co. of Ohio*	*State Tracking Number:*	*39867*
Company Tracking Number:	*U000310*		
TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*Informational Filing Related to Previously Approved Application U000310*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Accepted For Informational Purposes	Linda Bird	08/15/2008	08/15/2008

Amendments

Item	Schedule	Created By	Created On	Date Submitted
Previously Approved Application	Supporting Document	June Stracener	08/12/2008	08/12/2008
Authorization Letter	Supporting Document	June Stracener	08/06/2008	08/06/2008
Cover Letter dated 8-6-08	Supporting Document	June Stracener	08/06/2008	08/06/2008
Previously Approved Application	Supporting Document	June Stracener	08/06/2008	08/06/2008

SERFF Tracking Number:	*MWSG-125760358*	*State:*	*Arkansas*
Filing Company:	*Western Reserve Life Assurance Co. of Ohio*	*State Tracking Number:*	*39867*
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Product Name:	*Informational Filing Related to Previously Approved Application U000310*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 08/15/2008
Implementation Date:
Status: Accepted For Informational Purposes
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*MWSG-125760358*	*State:*	*Arkansas*
Filing Company:	*Western Reserve Life Assurance Co. of Ohio*	*State Tracking Number:*	*39867*
Company Tracking Number:	*U000310*		
TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*Informational Filing Related to Previously Approved Application U000310*		
Project Name/Number:	*/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		No
Supporting Document	Application		No
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		No
Supporting Document	Authorization Letter		Yes
Supporting Document	Cover Letter dated 8-6-08		Yes
Supporting Document *(revised)*	Previously Approved Application		Yes
Supporting Document	Previously Approved Application		Yes

SERFF Tracking Number:	*MWSG-125760358*	*State:*	*Arkansas*
Filing Company:	*Western Reserve Life Assurance Co. of Ohio*	*State Tracking Number:*	*39867*
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TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*Informational Filing Related to Previously Approved Application U000310*		
Project Name/Number:	*/*		

Amendment Letter

Amendment Date:

Submitted Date: 08/12/2008

Comments:

Enclosed please find an updated copy of application form number U000310, which was included as a supporting document. An extra page entitled Agent's Report was inadvertently attached to the form. This error has been corrected with the enclosed form, and the Company certifies that no other changes have been made to this form. Please accept our apologies for any inconvenience this may have caused.

Thank you for your courtesy and assistance.

Changed Items:

Supporting Document Schedule Item Changes:

User Added -Name: Previously Approved Application

Comment:

UPDATED U000310 STD FINAL.pdf

SERFF Tracking Number:	*MWSG-125760358*	*State:*	*Arkansas*
Filing Company:	*Western Reserve Life Assurance Co. of Ohio*	*State Tracking Number:*	*39867*
Company Tracking Number:	*U000310*		
TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*Informational Filing Related to Previously Approved Application U000310*		
Project Name/Number:	*/*		

Amendment Letter

Amendment Date:

Submitted Date: 08/06/2008

Comments:

Attached is an authorization letter, a cover letter and a copy of the previously approved application referenced in this filing.

Changed Items:

Supporting Document Schedule Item Changes:

User Added -Name: Authorization Letter

Comment:

Western Reserve Authorization Letter.pdf

User Added -Name: Cover Letter dated 8-6-08

Comment:

AR Cover Letter Dated 8-6-08.pdf

User Added -Name: Previously Approved Application

Comment:

U000310 STD FINAL.pdf

SERFF Tracking Number:	*MWSG-125760358*	*State:*	*Arkansas*
Filing Company:	*Western Reserve Life Assurance Co. of Ohio*	*State Tracking Number:*	*39867*
Company Tracking Number:	*U000310*		
TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*Informational Filing Related to Previously Approved Application U000310*		
Project Name/Number:	*/*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*MWSG-125760358*	*State:*	*Arkansas*
Filing Company:	*Western Reserve Life Assurance Co. of Ohio*	*State Tracking Number:*	*39867*
Company Tracking Number:	*U000310*		
TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*Informational Filing Related to Previously Approved Application U000310*		
Project Name/Number:	*/*		

Supporting Document Schedules

Review Status:

Satisfied -Name: Authorization Letter 08/06/2008

Comments:

Attachment:

Western Reserve Authorization Letter.pdf

Review Status:

Satisfied -Name: Cover Letter dated 8-6-08 08/06/2008

Comments:

Attachment:

AR Cover Letter Dated 8-6-08.pdf

Review Status:

Satisfied -Name: Previously Approved Application 08/12/2008

Comments:

Attachment:

UPDATED U000310 STD FINAL.pdf

Western Reserve Life Assurance Co. of Ohio
Administrative Office:
4333 Edgewood Road NE
Cedar Rapids, IA 52499
Home Office:
Columbus, Ohio
www.westernreserve.com

July 29, 2008

INSURANCE COMMISSIONER

This letter, or a copy thereof, will authorize Mitchell, Williams, Selig, Gates & Woodyard, P.L.L.C. to represent Western Reserve Life Assurance Co. of Ohio in any matters related to the submission of policy forms to your state.

Very truly yours,

Cheryl Bock

Cheryl Bock
Assistant Vice President of Contract Development

MITCHELL || WILLIAMS

DOAK FOSTER
DIRECT DIAL: 501-688-8841
E-MAIL: DFOSTER@MWSGW.COM

425 WEST CAPITOL AVENUE, SUITE 1800
LITTLE ROCK, ARKANSAS 72201-3525
TELEPHONE 501-688-8800
FAX 501-688-8807

August 6, 2008

The Honorable Julie Benafield Bowman
Commissioner of Insurance
Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

Attn: Mr. Dan Honey
Director, Life and Health

RE: **WESTERN RESERVE LIFE ASSURANCE CO. OF OHO**
(NAIC No. 91413; FEIN No. 43-1162657)

INFORMATIONAL FILING
- SERFF Tracking No. MWSG-125760358)

Dear Commissioner Bowman:

On behalf of our client, Western Reserve Life Assurance Co. of Ohio (the "Company"), we are submitting this informational filing which revises information surrounding the use of life application form U000310. Your Department approved this form on August 31, 20007, and a copy is included in this filing for your reference. Please note that the Company has not revised this form in any way. The Company intends to continue using the form in a traditional manner whereby the Owner/Applicant signs the application in ink and physically submits the application to the Company.

The Company now also plans to make this form available electronically. It is the Company's intent to use this form in a variety of electronic environments, including a laptop and web based application process. Regardless of the application process used, the Company intends to adopt measures to secure both the integrity of the document once signed, and the confidentiality of any information transmitted, including transmission of the information via a secured socket layer/secured line. The information contained in the application will be transmitted to the Company's administrative office electronically as well as the electronic signature of the Owner/Applicant. Current technology will be used to ensure that the confidential information is not comprised. All processes used will comply with the Uniform Electronic Transactions Act, and to the extent applicable, the Federal E-SIGN Act.

The Company certifies that any electronic signature it obtains will be linked to the date on the electronic application in such a manner that the electronic signature is invalidated if any of the data on the application is changed. The Company also certifies that such electronic signature intended for use with this application will not be affixed to or duplicated on any other document.

The Company intends to implement this use of the application on September 15, 2008. A copy of the application, identical to the filed form, will be printed and made part of any policy issued. Ohio is this Company's state of domicile.

If you have any questions or need anything further to expedite the review of this filing, please contact me at (501) 688-8841 or my paralegal, June Stracener at (501) 370-4225. Thank you for your assistance in this matter.

Sincerely,

MITCHELL, WILLIAMS, SELIG,
GATES & WOODYARD, P.L.L.C.

By Doak Foster by BP
Doak Foster

DF:ka
Enclosures
cc: Mr. Fred Alvarado
Mr. Stephanie Mara
Mr. Kevin Lyons

WRL®
INSURANCE • ANNUITIES
Western Reserve Life Assurance Co. of Ohio

WRL Freedom Choice Term II
WRL Freedom Index Universal Life

Application for Fixed Life Insurance

MAIL TO:
4333 Edgewood Road NE,
Cedar Rapids, Iowa 52499
Freedom Index Universal Life
1-800-322-3796
Freedom Choice Term II
1-800-625-4213

THIS APPLICATION PREPARED FOR

_____

_____
Application Prepared by

_____
Broker/Dealer

Application Checklist

Important Reminders	**DO:** ☐ Complete the entire application (front and back). ☐ Print application in blue or black ink. ☐ Have applicant initial all changes. ☐ Obtain all required signatures. ☐ Complete and sign the Agent's Report. ☐ Include certification if a trust or corporation is Owner and/or beneficiary of the policy. **DON'T:** ☐ Use pencil or whiteout. ☐ Accept or send money on applications that total more than $1,000,000.00 ☐ Submit an agent check as the initial premium. ☐ Submit starter checks or checking deposit slips for check-o-matic withdrawals.

PLEASE MAKE SURE ALL APPLICABLE FORMS WITHIN THE PACKET ARE COMPLETED

Leave with Applicant	**THE FOLLOWING PAGES NEED TO BE LEFT WITH THE CONSUMER:** ☐ Privacy Notice ☐ Conditional Receipt (If money taken with application) ☐ Notices page (Notice of Investigative Report, Disclosure of Information, and Insurance Information Practices) ☐ HIPAA Authorization for Release of Health Related Information

Agent Comments

Agent Comments

LIFE APPLICATION WRL – Western Reserve Life Assurance Co. of Ohio
Mailing Address: 4333 Edgewood Road NE, Cedar Rapids, IA 52499
Administrative Office: P.O. Box 5068, Clearwater, Florida 33758-5068

SECTION 1. PROPOSED PRIMARY INSURED/OWNER

Specified Amount $_____

1. Last Name | First Name | M.I.

2. Address (Cannot be a P.O. Box) | Apt# | City

State | Zip Code | 3. Years at Address | 4. Home Phone ( ) | 5. Driver License Number | State

6. Sex ☐ Male ☐ Female | 7. Date of Birth M M - D D - Y Y Y Y | 8. Age | 9. Place of Birth – State/Country | 10. Social Security Number

11. Height ft in | 12. Weight lbs | 13. Marital Status | 14. Employer | Years

15. Employer's Address and Phone Number

16. Occupation & Duties

17. Have you used **TOBACCO** or any other product containing **NICOTINE** in the last 5 years? ☐ Yes ☐ No Date last used_____

18. Rate Class Quoted: ☐ Preferred Elite ☐ Preferred Plus ☐ Preferred ☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco ☐ Juvenile

SECTION 2. PROPOSED ADDITIONAL INSURED

If more than one Additional Insured, please use Additional Insured Supplement. Specified Amount $ _____

We will allow the AIR death benefit recipient to be a choice of: ☐ Owner ☐ Primary Insured ☐ Same beneficiary as the base policy

1. Last Name | First Name | M.I.

2. Address (Cannot be a P.O. Box) | Apt# | City

State | Zip Code | 3. Years at Address | 4. Home Phone ( ) | 5. Driver License Number | State

6. Sex ☐ Male ☐ Female | 7. Date of Birth M M - D D - Y Y Y Y | 8. Age | 9. Place of Birth – State/Country | 10. Social Security Number

11. Height ft in | 12. Weight lbs | 13. Marital Status | 14. Relationship to proposed Primary Insured

15. Employer's Name, Address and Phone Number

16. Occupation & Duties | # Years

17. Have you used **TOBACCO** or any other product containing **NICOTINE** in the last 5 years? ☐ Yes ☐ No Date last used_____

18. Rate Class Quoted: ☐ Preferred Elite ☐ Preferred Plus ☐ Preferred ☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco ☐ Juvenile

SECTION 3. APPLICANT/OWNER IF OTHER THAN THE PROPOSED PRIMARY INSURED

If ownership is corporation, partnership or institutional body, please complete the Entity Certification of Authority form. If ownership is a trust, please complete the Trustee Certification Trust form. Attach a copy of the first page and the signature page of the Trust.

1. Last Name | First Name | M.I.

2. Address (Cannot be a P.O. Box) | Apt# | City

State | Zip Code | 3. Home Phone ( ) | 4. Social Security Number / Tax ID #

5. Sex ☐ Male ☐ Female | 6. Date of Birth/Trust Date M M - D D - Y Y Y Y | 7. Relationship to the proposed Primary Insured

8. Are you a citizen of ☐ USA ☐ Other Country_____ Type of VISA _____

SECTION 4. CHILDREN'S BENEFIT RIDER

Specified Amount $ _____

Name	Relationship	Date of Birth	Height	Weight
		M M — D D — Y Y Y Y	ft in	lbs
		M M — D D — Y Y Y Y	ft in	lbs
		M M — D D — Y Y Y Y	ft in	lbs

Are all children listed? ☐ Yes ☐ No Are children living with proposed Primary Insured? ☐ Yes ☐ No

If not, explain why:_____

SECTION 5. PRIMARY BENEFICIARY – If percentage shares are not listed below, they will be divided equally among the beneficiaries. If ownership or beneficiary is a corporation, partnership or institutional body, please complete the Entity Certification of Authority form. If ownership or beneficiary is a trust, please complete the Trustee Certification Trust form. Attach a copy of the first page and the signature page of the Trust.

Name	Percent	Relationship	Social Security Number/Tax ID#
Total	**1 0 0**		

SECTION 6. CONTINGENT BENEFICIARY – If percentage shares are not listed below, they will be divided equally among the beneficiaries.

Name	Percent	Relationship	Social Security Number/Tax ID#
Total	**1 0 0**		

SECTION 7. PROPOSED PLAN OF INSURANCE

☐ WRL Freedom Index UL
☐ WRL Freedom Choice Term II ☐ 10 ☐ 15 ☐ 20 ☐ 30

SECTION 8. DEATH BENEFIT OPTION (if applicable)

☐ Level Benefit ☐ Increasing Benefit

SECTION 9. LIFE INSURANCE COMPLIANCE TEST (if applicable)

☐ Guideline Premium Test
☐ Cash Value Accumulation Test (CVAT)

SECTION 10. ADDITIONAL BENEFITS–PRIMARY INSURED ONLY Not all applicable with all products.

☐ Base Insured Rider..... $_____,_____.____
☐ Accidental Death Benefit Rider..... $_____,_____.____
☐ Disability Income Rider (monthly benefit) ..... $_____,_____.____
☐ Disability Waiver of Monthly Deductions Rider
☐ Disability Waiver of Premium Rider
☐ Critical Illness Rider
☐ Other_____
☐ Other_____
☐ Other_____

SECTION 11. PREMIUMS PAYABLE

Initial Planned Premium..... $ _____,_____.____

☐ Single Premium ☐ Annually ☐ Semiannually ☐ Quarterly ☐ Monthly ☐ Other _____
☐ Electronic (bank draft) _____ Draft Date (1st thru 28th)
☐ Direct Bill

SECTION 12. PREMIUM ALLOCATIONS (Only for IUL)

Indicate your premium allocation percentages below. Total must equal 100%.

_____.0% Index Account
_____.0% Basic Interest Account
_____**100%** **Total**

SECTION 13. OTHER INSURANCE IN FORCE FOR ALL PROPOSED INSUREDS

Does the proposed Insured have existing life insurance, disability policies, critical illness or annuity contracts? ☐ Yes ☐ No

Proposed Insured Name	Company	Product Type	Amount of insurance	Year issued	Replacement?
					Yes No
					Yes No
					Yes No

IS THIS INTENDED TO BE A 1035 EXCHANGE? ☐ Yes ☐ No

Anticipated Cash Value Transfer $ _____,_____.____

A) Has any proposed Insured ever had life, disability or health insurance declined, rated, modified, issued with an exclusion rider, canceled, or not renewed? If yes, please explain._____ ☐ Yes ☐ No

B) Will the insurance applied for on any proposed Insured discontinue, replace or change any existing life or annuity policy? If yes, complete replacement forms, if appropriate. ☐ Yes ☐ No

C) Is there an application for life, accident or sickness insurance now pending or contemplated on any proposed Insured in this or any other company? If yes, give details in Agent's Report. ☐ Yes ☐ No

SECTION 14. PERSONAL FINANCIAL STATEMENT FOR PROPOSED PRIMARY INSURED

All financial information on non-juvenile business must be that of the proposed Primary Insured, not the Owner.

A) Gross Income Current Yr $ ____ , ____ . ____

B) Gross Income Previous Yr $ ____ , ____ . ____

C) Source of Funds ☐ Employment ☐ Retirement ☐ Inheritance ☐ 1035 Exchange ☐ Other_____

D) Current Net Worth $ ____ , ____ . ____

For over $1,000,000.00 applied coverage complete a separate Financial Questionnaire.

SECTION 15.BUSINESS FINANCIAL STATEMENT FOR PROPOSED PRIMARY INSURED

A) Current Estimated Market Value $ ____ , ____ , ____

B) Assets *Liquid* $ ____ , ____ , ____

Nonliquid $ ____ , ____ , ____

C) Liabilities $ ____ , ____ , ____

D) Net Worth $ ____ , ____ , ____

SECTION 16. MEDICAL QUESTIONS – Each question must be individually asked and answered for each proposed Insured.

Give the details to "No" answer for medical question 16A and "Yes" answers to questions 16B-E in Section 17 below:

A) For the last 180 days has the proposed Primary Insured been actively at work, on a full time basis, at their usual place of business or employment? ☐ Yes ☐ No

B) To the best of your knowledge, has any proposed Insured within the last 10 years had or been told by a member of the medical profession that he or she had, or has been treated for:

1) Heart murmur, high blood pressure, chest pain, heart attack, stroke, or other disorder of the heart or circulatory system? ☐ Yes ☐ No
2) Asthma, Emphysema, Chronic Bronchitis, Tuberculosis, or any other Respiratory disorder; colitis, ulcer or any other gastrointestinal disorder; jaundice, hepatitis, liver or kidney disorder? ☐ Yes ☐ No
3) Cancer, tumor, polyp, breast, prostate or any other reproductive disorder; or any thyroid or endocrine disorder? ☐ Yes ☐ No
4) Brain, seizure or mental disorder, anxiety, depression, suicide attempt or any paralysis? ☐ Yes ☐ No
5) Diabetes, anemia, or any disorder of the blood; sugar, protein, or blood in the urine? ☐ Yes ☐ No

C) To the best of your knowledge, has any proposed Insured within the last 10 years:

1) Used amphetamines, heroin, cocaine, marijuana, or any other illegal or controlled substance except as prescribed by a physician? ☐ Yes ☐ No
2) Sought or been advised to seek treatment, limit or discontinue use of alcohol? ☐ Yes ☐ No
3) Been on or are now on prescribed medication or prescribed diet? ☐ Yes ☐ No
4) Had or been advised to have any hospitalization, surgery, or any diagnostic test including, but not limited to, electrocardiograms, blood studies, scans, MRI's or other test? ☐ Yes ☐ No
5) Had an examination, treatment or consultation with a doctor or health care provider other than above? ☐ Yes ☐ No

D) Within the last 10 years, has any proposed Insured been told by a member of the medical profession that he or she had a diagnosis of AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or the HIV (Human Immunodeficiency Virus) infection? ☐ Yes ☐ No

E) Has the proposed Primary Insured had a parent, brother, or sister who had any occurrence of or death from coronary artery disease, cardiovascular disease, internal cancer or melanoma prior to age 60? ☐ Yes ☐ No

SECTION 17. DETAILS TO ANSWERS FOR MEDICAL QUESTIONS Identify question number; state diagnosis, dates, duration, treatment, results and medications of each illness or injury. List the name, full address, phone number, and dates of each health care provider consulted.

Question #	Proposed Insured's Name	Diagnosis, Dates, Durations, Treatments, Results and Medications	Name, Address and Phone # of Attending Doctor and Hospital

SECTION 18. PERSONAL PHYSICIAN (if none, so state)

Proposed Insured's Name	Date Last Seen, Reason and Results	Name, Address and Phone # of Attending Doctor and Hospital

SECTION 19. RESIDENCY – Each question must be individually asked and answered for each proposed Insured.

A) The proposed Insured is a citizen of ☐ USA ☐ Other Country _____ Type of VISA_____

B) How many years has the proposed Insured resided in the USA?_____

C) Does any proposed Insured travel outside the USA? ☐ Yes ☐ No

If yes, provide details: include name of proposed Insured, destination, number of trips, duration of each trip, purpose of trip, plans for the next year._____

_____

SECTION 20. DRIVING AND PUBLIC RECORDS –Each question must be individually asked and answered for each proposed Insured.

A) Has any proposed Insured had their driver's license suspended, restricted, revoked, or been cited for a moving violation in the last 5 years? ☐ Yes ☐ No If yes, include name of proposed Insured and give reason:

_____

_____

B) Has any proposed Insured in the last ten years been convicted of a misdemeanor (other than a minor traffic violation) or felony? ☐ Yes ☐ No If yes, include name of proposed Insured and give reason:

_____

_____

SECTION 21. SPECIAL ACTIVITIES – Each question must be individually asked and answered for each proposed Insured.

A) Except as a passenger on a regularly scheduled flight, has any proposed Insured flown within the past 2 years, or does any proposed Insured have plans to fly in the future? If yes, complete the Avocation and Aviation Questionnaire. ☐ Yes ☐ No

B) In the past 2 years has any proposed Insured participated in organized racing (automobile, motorcycle, or boat), underwater or sky diving, hang gliding, canyoneering, mountain or rock climbing? If yes, complete the Avocation and Aviation Questionnaire. ☐ Yes ☐ No

SECTION 22. TRANSFER AUTHORIZATION–TO BE COMPLETED BY APPLICANT/OWNER (only for IUL)

Transfer Authorization:

Your policy applied for, if issued, will automatically receive transfer privileges, unless declined below. These privileges only allow the Owner and agent of record to change premium allocations and transfer between the Basic Interest Account and the Index Account. Transfers are subject to the restrictions/guidelines outlined in the Statement of Understanding.

Western Reserve Life Assurance Co. of Ohio will not be liable for complying with transfer instructions it reasonably believes to be authentic, nor for any loss, damage, costs or expense in acting on such instructions, and Policy Owners will bear the risk of any such loss. Western Reserve Life Assurance Co. of Ohio will employ reasonable procedures to confirm that transfer instructions are genuine. If Western Reserve Life Assurance Co. of Ohio does not employ such procedures, it may be liable for losses due to unauthorized or fraudulent instructions. These procedures include but are not limited to requiring forms of personal identification prior to acting upon such transfer instruction, providing written confirmation of such transactions to the Owner and/or tape recording of telephone transfer request instructions received.

☐ The agent does **not** have authority to make transfers or change payment allocations on my behalf.

SECTION 23. OTHER INSURANCE–TO BE COMPLETED BY THE AGENT

A) Will the policy applied for discontinue, replace or change any existing life insurance policy or annuity? ☐ Yes ☐ No

B) If mandated by your state, did you present, read and leave a copy of the Replacement Notice with the Applicant/Owner at time of application? ☐ Yes ☐ No

(In some states the Replacement Notice must be completed and sent in with the application whether or not the Applicant/Owner intends to replace existing coverage.)

C) Did you present and leave the Applicant/Owner approved sales material? ☐ Yes ☐ No

SECTION 24. ILLUSTRATION CERTIFICATION (if applicable) **The box below MUST be checked if a signed illustration of the policy applied for is NOT enclosed with this application.**

☐ The Applicant/Owner and the Licensed Agent certify that they have each read and agree with their respective statements below regarding the policy applied for:

Applicant's/Owner's statement: By signing this application, I, the Applicant/Owner acknowledge that I have NOT received an illustration of the policy applied for and understand that an illustration of the policy as issued will be provided no later than the policy delivery date. **Licensed Agent's statement:** By signing this application, I, the Licensed Agent certify that I have NOT provided an illustration of the policy as applied for. However, I will provide an illustration conforming to the policy as issued upon or prior to delivery of the policy.

SECTION 25. TAXPAYER IDENTIFICATION CERTIFICATION

Under current federal tax laws, the Company is required to obtain your Taxpayer Identification Number (e.g., a social security or employer identification number, or "TIN") and certification that you are not subject to backup withholding. Please review the following certification and sign accordingly.

Under penalties of perjury, I certify that (1) the TIN listed in this application is my correct TIN; (2) I have not been notified that I am subject to backup withholding or I am not subject to backup withholding because I am an exempt recipient; and (3) I am a U.S. Person (U.S. citizen/legal resident). If not a U.S. Person, I have completed the appropriate Form W-8BEN. The IRS does not require your consent to any provision of this form other than this certification.

Signature of Owner _____ **Date** _____

SECTION 26. AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Each of the undersigned hereby certifies and represents as follows: The statements and answers given on this application are true and correct. I acknowledge and agree (A) that this application and any amendments shall be the basis for any insurance issued; (B) that the agent does not have the authority to waive any question on this application, to decide if insurance will be issued, or to modify any term or provision of any insurance which may be issued based on this application, only a writing signed by an officer of the Company can change the terms of this application or the terms of any insurance issued by the Company; (C) except as provided in the Conditional Receipt, if issued with the same proposed Insured(s) as on this application, no policy applied for shall take effect until after all of the following conditions have been met: 1) the minimum initial premium must be received by the Company; 2) the proposed Owner must have personally received and accepted the policy during the lifetime of all proposed Insured(s) and while all proposed Insured(s) are in good health; and 3) on the date of the later of either 1) or 2) above, all of the statements and answers given in this application must be true and complete, and the insurance will not take effect if the facts have changed. Unless otherwise stated the undersigned applicant is the premium payor and Owner of the policy applied for.

I authorize MIB Group, Inc. and its members or affiliates, my employer or former employer, any consumer reporting agency or governmental agency, medical provider, or any insurer or reinsurer to provide medical or personal information about me that is reasonably required for the purposes stated in this authorization to Western Reserve Life Assurance Co. of Ohio, its administrators, representatives or its reinsurers. I understand the information obtained by use of the authorization will be used by Western Reserve Life Assurance Co. of Ohio to determine eligibility for insurance, and eligibility for benefits under an existing policy. Any information obtained will not be released by Western Reserve Life Assurance Co. of Ohio to any person or organization except to reinsurers, MIB Group, Inc. and its members or affiliates, or other persons or organizations performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may authorize. This authorization will expire 30 months (24 months in Iowa, Kentucky, New Mexico and Wyoming) from the date signed. A copy of this authorization shall be as valid as the original. Either my authorized representative or I may receive a copy of this authorization upon request.

The Company shall have sixty days from the date hereof within which to consider and act on this application and if within such period a policy has not been received by the applicant or if notice of approval or rejection has not been given, then this application shall be deemed to have been declined by the Company.

I acknowledge receipt of the (1) Notice to Persons Applying for Insurance Regarding Investigative Report, (2) MIB Group, Inc. Pre-Notification, and (3) Notice of Insurance Information Practices.

I understand that any omissions or misstatements in this application could cause an otherwise valid claim to be denied under any insurance issued from this application.

I also understand that I will not receive any insurance coverage for any money paid with this application unless a policy is issued except in accordance with the terms of the Conditional Receipt.

Signed at _____ (city) _____ (state) on MM – DD – YYYY (date)

_____ Signature of proposed Primary Insured/Owner (Child over age 15 must sign)	_____ Print Agent Name
_____ Signature of parent or legal guardian for Insured(s) 15 and under	_____ Agent #
_____ Signature of proposed Additional Insured	
_____ Signature of Applicant/Owner if other than the proposed Primary Insured (If business insurance, show title of officer and name of firm. If trust, show trustee's name)	_____ Signature of Agent/Licensed Rep.
	_____ Signature of Split Agent/Licensed Rep.

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FRAUD WARNING

The following state(s) and U.S. territories require that insurance applicants acknowledge a fraud warning statement. Please refer to the fraud warning statement for your state or U.S. territory as indicated below.

For applicants in ARKANSAS, LOUISIANA and WEST VIRGINIA

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Applicant's Signature Date

For applicants in COLORADO

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Applicant's Signature Date

For applicants in DISTRICT OF COLUMBIA

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Applicant's Signature Date

For applicants in FLORIDA

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Applicant's Signature Date

For applicants in KENTUCKY

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Applicant's Signature Date

For applicants in MAINE and TENNESSEE

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Applicant's Signature Date

For applicants in NEW JERSEY

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Applicant's Signature Date

For applicants in NEW MEXICO

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Applicant's Signature Date

For applicants in OHIO

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Applicant's Signature Date

For applicants in OKLAHOMA

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Applicant's Signature Date

For applicants in PENNSYLVANIA

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Applicant's Signature Date

For applicants in PUERTO RICO

Any person who knowingly, and with the intention to defraud, includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony, and if found guilty, shall be punished for each violation with a fine of no less than five thousand dollars ($5000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Applicant's Signature Date

For applicants in VIRGINIA and WASHINGTON

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Applicant's Signature Date

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CONDITIONAL RECEIPT

(Detach and leave with applicant only if money is submitted with application. **If within the past 12 months any proposed Insured has been treated for or experienced heart trouble, stroke or cancer, no payment may be accepted with the application.** Do not accept money unless all required signatures below are obtained.)

PLEASE READ THIS CAREFULLY

No coverage will become effective prior to the delivery of the policy applied for unless and until all conditions of this receipt have been fulfilled exactly. No agent or field representative is authorized to waive or modify any of the provisions of the conditional receipt.

Make all checks payable to the Company. Do not make checks payable to the agent or leave the payee blank or you may jeopardize the insurance for which you have applied.

Received from _____, the sum of $_____ for the insurance application dated _____, with _____ as the proposed Insured(s). The policy you applied for will not become effective unless and until a policy contract is delivered to you and all other conditions of coverage are met. However, subject to the conditions and limitations of this Receipt, conditional insurance under the terms of the policy applied for may become effective as of the later of (1) the date of application and (2) the date of the last medical examination, tests, and other screenings required by the Company, if any (the "Effective Date"). Such conditional insurance will take effect as of the Effective Date, so long as all of the following requirements are met:

1. Each person proposed to be Insured is found to have been insurable as of the Effective Date, exactly as applied for in accordance with the Company's underwriting rules and standards, without any modifications as to plan, amount, or premium rate;
2. As of the Effective Date, all statements and answers given in the application must be true;
3. The payment made with the application must not be less than the full initial premium for the mode of payment chosen in the application, must be received at our Administrative Office within the lifetime of the proposed Insured to whom the conditional coverage would apply and, if in the form of check or draft, must be honored for payment;
4. All medical examinations, tests, and other screenings required of the proposed Insured by the Company are completed and the results received at our Administrative Office within 60 days of the date the application was completed; and
5. All parts of the application, any supplemental application, questionnaires, addendum and/or amendment to the application are signed and received at our Administrative Office.

Any conditional coverage provided by this Receipt will terminate on the earliest of: (a) 60 days from the date the application was signed; (b) the date the Company either mails notice to the applicant of the rejection of the application and/or mails a refund of any amounts paid with the application; (c) when the insurance applied for goes into effect under the terms of the policy applied for; or (d) the date the Company offers to provide insurance on terms that differ from the insurance for which you have applied.

If one or more of this Receipt's conditions have not been met exactly, or if a proposed Insured dies by suicide, the Company will not be liable except to return any payment made with the application.

If the Company does not approve and accept the application for insurance within 60 days of the date you signed the application, the application will be deemed to be rejected by the Company and there will be no conditional insurance coverage. In that case, the Company's liability will be limited to returning any payment(s) you have made upon return of this Receipt to the Company.

The aggregate amount of conditional coverage provided under this Receipt, if any, and any other conditional receipt issued by the Company shall be limited to the lesser of the amount(s) applied for or $500,000 of life insurance. There is no conditional coverage for riders or any additional benefits, if any, for which you have applied.

Authorization (Signatures Required)
I certify that I have read and reviewed the Conditional Receipt and the Authorization to Obtain and Disclose Information in the application. The terms and conditions of the Conditional Receipt have been explained to me fully by the agent and I understand them.

Dated at _____ on _____ _____

City, State | Date | Signature of Agent or Authorized Company Rep

_____ _____

Signature of proposed Insured | Signature of Applicant (if other than proposed Insured)

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NOTICES

DETACH AND LEAVE THIS PAGE WITH APPLICANT

NOTICE TO PERSONS APPLYING FOR INSURANCE REGARDING INVESTIGATIVE REPORT

To proposed Insured: In connection with this application, an investigative consumer report may be prepared about you. Such reports are part of the process of evaluating risks for life and health insurance. Typically, this report will contain information about your character, general reputation, personal characteristics and mode of living. The information in the report may be obtained by talking with you or members of your family, business associates, financial sources, neighbors, and others you know. You may ask to be interviewed in connection with the preparation of any such report. Also, we may have the report updated if you apply for more coverage.

Upon your written request, we will let you know whether a report was prepared and we will give you the name, address, and telephone number of the agency preparing the report. By contacting that agency and providing proper identification, you may obtain a copy of the report.

MIB GROUP, INC. (MIB) PRE-NOTIFICATION

To proposed Insured and other persons proposed to be insured, if any. Information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report on this information to MIB Group, Inc., a non-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB may, upon request, supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: Post Office Box 105, Essex Station, Boston, Massachusetts 02122; and telephone number is 866-692-6901 (TTY 866-346-3642 for hearing impaired).

NOTICE OF INSURANCE INFORMATION PRACTICES

To proposed Insured: Personal information may be collected from persons other than the individual(s) proposed for coverage. Such information as well as other personal or privileged information subsequently collected by us or our agent may in certain circumstances be disclosed to third parties without authorization. Upon request, you have the right to access your personal information and ask for corrections. You may obtain a complete description of our Information Practices by writing to Western Reserve Life Assurance Co. of Ohio, Attn: Director of Underwriting, 4333 Edgewood Road NE, Cedar Rapids, Iowa 52499.

PLEASE PROVIDE A COPY OF THIS NOTICE TO THE PROPOSED INSURED IF NOT A HOUSEHOLD MEMBER.

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Additional Insured Supplement

SECTION 1. PROPOSED ADDITIONAL INSURED **SPECIFIED AMOUNT $_____**

We will allow the AIR death benefit recipient to be a choice of: ☐ Owner ☐ Primary Insured ☐ Same beneficiary as the base policy

1. Last Name	First Name	M.I.
2. Address (Cannot be a P.O. Box)	Apt#	City

State	Zip Code	3. Years at Address	4. Home Phone ( )	5. Driver License Number	State
6. Sex ☐ Male ☐ Female	7. Date of Birth M M - D D - Y Y Y Y	8. Age	9. Place of Birth – State/Country	10. Social Security Number	
11. Height ft in	12. Weight lbs	13. Marital Status	14. Relationship to proposed Primary Insured		

15. Employer's Name, Address and Phone Number

16. Occupation & Duties # Years

17. Have you used **TOBACCO** or any other product containing **NICOTINE** in the last 5 years? ☐ Yes ☐ No Date last used_____

18. Rate Class Quoted: ☐ Preferred Elite ☐ Preferred Plus ☐ Preferred ☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco ☐ Juvenile

SECTION 2. PROPOSED ADDITIONAL INSURED **SPECIFIED AMOUNT $_____**

We will allow the AIR death benefit recipient to be a choice of: ☐ Owner ☐ Primary Insured ☐ Same beneficiary as the base policy

1. Last Name	First Name	M.I.
2. Address (Cannot be a P.O. Box)	Apt#	City

State	Zip Code	3. Years at Address	4. Home Phone ( )	5. Driver License Number	State
6. Sex ☐ Male ☐ Female	7. Date of Birth M M - D D - Y Y Y Y	8. Age	9. Place of Birth – State/Country	10. Social Security Number	
11. Height ft in	12. Weight lbs	13. Marital Status	14. Relationship to proposed Primary Insured		

15. Employer's Name, Address and Phone Number

16. Occupation & Duties # Years

17. Have you used **TOBACCO** or any other product containing **NICOTINE** in the last 5 years? ☐ Yes ☐ No Date last used_____

18. Rate Class Quoted: ☐ Preferred Elite ☐ Preferred Plus ☐ Preferred ☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco ☐ Juvenile

SECTION 3. PROPOSED ADDITIONAL INSURED **SPECIFIED AMOUNT $_____**

We will allow the AIR death benefit recipient to be a choice of: ☐ Owner ☐ Primary Insured ☐ Same beneficiary as the base policy

1. Last Name	First Name	M.I.
2. Address (Cannot be a P.O. Box)	Apt#	City

State	Zip Code	3. Years at Address	4. Home Phone ( )	5. Driver License Number	State
6. Sex ☐ Male ☐ Female	7. Date of Birth M M - D D - Y Y Y Y	8. Age	9. Place of Birth – State/Country	10. Social Security Number	
11. Height ft in	12. Weight lbs	13. Marital Status	14. Relationship to proposed Primary Insured		

15. Employer's Name, Address and Phone Number

16. Occupation & Duties # Years

17. Have you used **TOBACCO** or any other product containing **NICOTINE** in the last 5 years? ☐ Yes ☐ No Date last used_____

18. Rate Class Quoted: ☐ Preferred Elite ☐ Preferred Plus ☐ Preferred ☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco ☐ Juvenile

SECTION 4. PROPOSED ADDITIONAL INSURED

SPECIFIED AMOUNT $_____

We will allow the AIR death benefit recipient to be a choice of: ☐ Owner ☐ Primary Insured ☐ Same beneficiary as the base policy

1. Last Name	First Name	M.I.

2. Address (Cannot be a P.O. Box)	Apt#	City

State	Zip Code	3. Years at Address	4. Home Phone ( )	5. Driver License Number	State

6. Sex ☐ Male ☐ Female	7. Date of Birth M M - D D - Y Y Y Y	8. Age	9. Place of Birth – State/Country	10. Social Security Number

11. Height ft in	12. Weight lbs	13. Marital Status	14. Relationship to proposed Primary Insured

15. Employer's Name, Address and Phone Number

16. Occupation & Duties	# Years

17. Have you used **TOBACCO** or any other product containing **NICOTINE** in the last 5 years? ☐ Yes ☐ No Date last used _____

18. Rate Class Quoted: ☐ Preferred Elite ☐ Preferred Plus ☐ Preferred ☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco ☐ Juvenile

SECTION 5. DECLARATIONS

I (We) represent that all statements and answers made in this supplement are full, complete and true to the best of my (our) knowledge and belief. It is agreed that this statement shall be made part of the application, and is subject to all terms and conditions contained in the application.

Signed at _____ (city) _____ (state) on M M - D D - Y Y Y Y (date)

sec. 1 _____
Signature of proposed Additional Insured
(Child over 15 must sign)

sec. 3 _____
Signature of proposed Additional Insured
(Child over 15 must sign)

sec. 2 _____
Signature of proposed Additional Insured
(Child over 15 must sign)

sec. 4 _____
Signature of proposed Additional Insured
(Child over 15 must sign)

_____
Signature of Parent or Legal Guardian for Insured(s) 15 and under

_____
Signature of Applicant/Owner, if other than the proposed Primary Insured (If business insurance, show title of officer and name of firm. If trust, show trustee's name)

_____
Witness (Registered Representative)

SERFF Tracking Number:	*MWSG-125760358*	*State:*	*Arkansas*
Filing Company:	*Western Reserve Life Assurance Co. of Ohio*	*State Tracking Number:*	*39867*
Company Tracking Number:	*U000310*		
TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*Informational Filing Related to Previously Approved Application U000310*		
Project Name/Number:	*/*		

Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Supporting Document	Previously Approved Application	08/06/2008	U000310 STD FINAL.pdf

WRL®
INSURANCE • ANNUITIES
Western Reserve Life Assurance Co. of Ohio

WRL Freedom Choice Term II
WRL Freedom Index Universal Life

Application for Fixed Life Insurance

MAIL TO:
4333 Edgewood Road NE,
Cedar Rapids, Iowa 52499
Freedom Index Universal Life
1-800-322-3796
Freedom Choice Term II
1-800-625-4213

THIS APPLICATION PREPARED FOR

_____

_____
Application Prepared by

_____
Broker/Dealer

Application Checklist

Important Reminders	**DO:** ☐ Complete the entire application (front and back). ☐ Print application in blue or black ink. ☐ Have applicant initial all changes. ☐ Obtain all required signatures. ☐ Complete and sign the Agent's Report. ☐ Include certification if a trust or corporation is Owner and/or beneficiary of the policy. **DON'T:** ☐ Use pencil or whiteout. ☐ Accept or send money on applications that total more than $1,000,000.00 ☐ Submit an agent check as the initial premium. ☐ Submit starter checks or checking deposit slips for check-o-matic withdrawals.

PLEASE MAKE SURE ALL APPLICABLE FORMS WITHIN THE PACKET ARE COMPLETED

Leave with Applicant	**THE FOLLOWING PAGES NEED TO BE LEFT WITH THE CONSUMER:** ☐ Privacy Notice ☐ Conditional Receipt (If money taken with application) ☐ Notices page (Notice of Investigative Report, Disclosure of Information, and Insurance Information Practices) ☐ HIPAA Authorization for Release of Health Related Information

Agent Comments

Agent Comments

LIFE APPLICATION WRL – Western Reserve Life Assurance Co. of Ohio
Mailing Address: 4333 Edgewood Road NE, Cedar Rapids, IA 52499
Administrative Office: P.O. Box 5068, Clearwater, Florida 33758-5068

SECTION 1. PROPOSED PRIMARY INSURED/OWNER

Specified Amount $_____

1. Last Name | First Name | M.I.

2. Address (Cannot be a P.O. Box) | Apt# | City

State | Zip Code | 3. Years at Address | 4. Home Phone ( ) | 5. Driver License Number | State

6. Sex ☐ Male ☐ Female | 7. Date of Birth M M - D D - Y Y Y Y | 8. Age | 9. Place of Birth – State/Country | 10. Social Security Number

11. Height ft in | 12. Weight lbs | 13. Marital Status | 14. Employer | Years

15. Employer's Address and Phone Number

16. Occupation & Duties

17. Have you used **TOBACCO** or any other product containing **NICOTINE** in the last 5 years? ☐ Yes ☐ No Date last used_____

18. Rate Class Quoted: ☐ Preferred Elite ☐ Preferred Plus ☐ Preferred ☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco ☐ Juvenile

SECTION 2. PROPOSED ADDITIONAL INSURED

If more than one Additional Insured, please use Additional Insured Supplement. Specified Amount $ _____

We will allow the AIR death benefit recipient to be a choice of: ☐ Owner ☐ Primary Insured ☐ Same beneficiary as the base policy

1. Last Name | First Name | M.I.

2. Address (Cannot be a P.O. Box) | Apt# | City

State | Zip Code | 3. Years at Address | 4. Home Phone ( ) | 5. Driver License Number | State

6. Sex ☐ Male ☐ Female | 7. Date of Birth M M - D D - Y Y Y Y | 8. Age | 9. Place of Birth – State/Country | 10. Social Security Number

11. Height ft in | 12. Weight lbs | 13. Marital Status | 14. Relationship to proposed Primary Insured

15. Employer's Name, Address and Phone Number

16. Occupation & Duties | # Years

17. Have you used **TOBACCO** or any other product containing **NICOTINE** in the last 5 years? ☐ Yes ☐ No Date last used_____

18. Rate Class Quoted: ☐ Preferred Elite ☐ Preferred Plus ☐ Preferred ☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco ☐ Juvenile

SECTION 3. APPLICANT/OWNER IF OTHER THAN THE PROPOSED PRIMARY INSURED

If ownership is corporation, partnership or institutional body, please complete the Entity Certification of Authority form. If ownership is a trust, please complete the Trustee Certification Trust form. Attach a copy of the first page and the signature page of the Trust.

1. Last Name | First Name | M.I.

2. Address (Cannot be a P.O. Box) | Apt# | City

State | Zip Code | 3. Home Phone ( ) | 4. Social Security Number / Tax ID #

5. Sex ☐ Male ☐ Female | 6. Date of Birth/Trust Date M M - D D - Y Y Y Y | 7. Relationship to the proposed Primary Insured

8. Are you a citizen of ☐ USA ☐ Other Country_____ Type of VISA _____

SECTION 4. CHILDREN'S BENEFIT RIDER

Specified Amount $ _____

Name	Relationship	Date of Birth	Height	Weight
		M M — D D — Y Y Y Y	ft in	lbs
		M M — D D — Y Y Y Y	ft in	lbs
		M M — D D — Y Y Y Y	ft in	lbs

Are all children listed? ☐ Yes ☐ No Are children living with proposed Primary Insured? ☐ Yes ☐ No

If not, explain why:_____

SECTION 5. PRIMARY BENEFICIARY – If percentage shares are not listed below, they will be divided equally among the beneficiaries. If ownership or beneficiary is a corporation, partnership or institutional body, please complete the Entity Certification of Authority form. If ownership or beneficiary is a trust, please complete the Trustee Certification Trust form. Attach a copy of the first page and the signature page of the Trust.

Name	Percent	Relationship	Social Security Number/Tax ID#
Total	**1 0 0**		

SECTION 6. CONTINGENT BENEFICIARY – If percentage shares are not listed below, they will be divided equally among the beneficiaries.

Name	Percent	Relationship	Social Security Number/Tax ID#
Total	**1 0 0**		

SECTION 7. PROPOSED PLAN OF INSURANCE

☐ WRL Freedom Index UL
☐ WRL Freedom Choice Term II ☐ 10 ☐ 15 ☐ 20 ☐ 30

SECTION 8. DEATH BENEFIT OPTION (if applicable)

☐ Level Benefit ☐ Increasing Benefit

SECTION 9. LIFE INSURANCE COMPLIANCE TEST (if applicable)

☐ Guideline Premium Test
☐ Cash Value Accumulation Test (CVAT)

SECTION 10. ADDITIONAL BENEFITS–PRIMARY INSURED ONLY Not all applicable with all products.

☐ Base Insured Rider..... $_____,_____.____
☐ Accidental Death Benefit Rider..... $_____,_____.____
☐ Disability Income Rider (monthly benefit) ..... $_____,_____.____
☐ Disability Waiver of Monthly Deductions Rider
☐ Disability Waiver of Premium Rider
☐ Critical Illness Rider
☐ Other_____
☐ Other_____
☐ Other_____

SECTION 11. PREMIUMS PAYABLE

Initial Planned Premium..... $ _____,_____.____

☐ Single Premium ☐ Annually ☐ Semiannually ☐ Quarterly ☐ Monthly ☐ Other _____
☐ Electronic (bank draft) _____ Draft Date (1st thru 28th)
☐ Direct Bill

SECTION 12. PREMIUM ALLOCATIONS (Only for IUL)

Indicate your premium allocation percentages below. Total must equal 100%.

_____.0% Index Account
_____.0% Basic Interest Account
_____**100%** **Total**

SECTION 13. OTHER INSURANCE IN FORCE FOR ALL PROPOSED INSUREDS

Does the proposed Insured have existing life insurance, disability policies, critical illness or annuity contracts? ☐ Yes ☐ No

Proposed Insured Name	Company	Product Type	Amount of insurance	Year issued	Replacement?
					Yes No
					Yes No
					Yes No

IS THIS INTENDED TO BE A 1035 EXCHANGE? ☐ Yes ☐ No

Anticipated Cash Value Transfer $ _____,_____.____

A) Has any proposed Insured ever had life, disability or health insurance declined, rated, modified, issued with an exclusion rider, canceled, or not renewed? If yes, please explain._____ ☐ Yes ☐ No

B) Will the insurance applied for on any proposed Insured discontinue, replace or change any existing life or annuity policy? If yes, complete replacement forms, if appropriate. ☐ Yes ☐ No

C) Is there an application for life, accident or sickness insurance now pending or contemplated on any proposed Insured in this or any other company? If yes, give details in Agent's Report. ☐ Yes ☐ No

SECTION 14. PERSONAL FINANCIAL STATEMENT FOR PROPOSED PRIMARY INSURED

All financial information on non-juvenile business must be that of the proposed Primary Insured, not the Owner.

A) Gross Income Current Yr $ ____ , ____ . ____

B) Gross Income Previous Yr $ ____ , ____ . ____

C) Source of Funds ☐ Employment ☐ Retirement ☐ Inheritance ☐ 1035 Exchange ☐ Other_____

D) Current Net Worth $ ____ , ____ . ____

For over $1,000,000.00 applied coverage complete a separate Financial Questionnaire.

SECTION 15.BUSINESS FINANCIAL STATEMENT FOR PROPOSED PRIMARY INSURED

A) Current Estimated Market Value $ ____ , ____ , ____

B) Assets *Liquid* $ ____ , ____ , ____

Nonliquid $ ____ , ____ , ____

C) Liabilities $ ____ , ____ , ____

D) Net Worth $ ____ , ____ , ____

SECTION 16. MEDICAL QUESTIONS – Each question must be individually asked and answered for each proposed Insured.

Give the details to "No" answer for medical question 16A and "Yes" answers to questions 16B-E in Section 17 below:

A) For the last 180 days has the proposed Primary Insured been actively at work, on a full time basis, at their usual place of business or employment? ☐ Yes ☐ No

B) To the best of your knowledge, has any proposed Insured within the last 10 years had or been told by a member of the medical profession that he or she had, or has been treated for:

1) Heart murmur, high blood pressure, chest pain, heart attack, stroke, or other disorder of the heart or circulatory system? ☐ Yes ☐ No
2) Asthma, Emphysema, Chronic Bronchitis, Tuberculosis, or any other Respiratory disorder; colitis, ulcer or any other gastrointestinal disorder; jaundice, hepatitis, liver or kidney disorder? ☐ Yes ☐ No
3) Cancer, tumor, polyp, breast, prostate or any other reproductive disorder; or any thyroid or endocrine disorder? ☐ Yes ☐ No
4) Brain, seizure or mental disorder, anxiety, depression, suicide attempt or any paralysis? ☐ Yes ☐ No
5) Diabetes, anemia, or any disorder of the blood; sugar, protein, or blood in the urine? ☐ Yes ☐ No

C) To the best of your knowledge, has any proposed Insured within the last 10 years:

1) Used amphetamines, heroin, cocaine, marijuana, or any other illegal or controlled substance except as prescribed by a physician? ☐ Yes ☐ No
2) Sought or been advised to seek treatment, limit or discontinue use of alcohol? ☐ Yes ☐ No
3) Been on or are now on prescribed medication or prescribed diet? ☐ Yes ☐ No
4) Had or been advised to have any hospitalization, surgery, or any diagnostic test including, but not limited to, electrocardiograms, blood studies, scans, MRI's or other test? ☐ Yes ☐ No
5) Had an examination, treatment or consultation with a doctor or health care provider other than above? ☐ Yes ☐ No

D) Within the last 10 years, has any proposed Insured been told by a member of the medical profession that he or she had a diagnosis of AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or the HIV (Human Immunodeficiency Virus) infection? ☐ Yes ☐ No

E) Has the proposed Primary Insured had a parent, brother, or sister who had any occurrence of or death from coronary artery disease, cardiovascular disease, internal cancer or melanoma prior to age 60? ☐ Yes ☐ No

SECTION 17. DETAILS TO ANSWERS FOR MEDICAL QUESTIONS Identify question number; state diagnosis, dates, duration, treatment, results and medications of each illness or injury. List the name, full address, phone number, and dates of each health care provider consulted.

Question #	Proposed Insured's Name	Diagnosis, Dates, Durations, Treatments, Results and Medications	Name, Address and Phone # of Attending Doctor and Hospital

SECTION 18. PERSONAL PHYSICIAN (if none, so state)

Proposed Insured's Name	Date Last Seen, Reason and Results	Name, Address and Phone # of Attending Doctor and Hospital

SECTION 19. RESIDENCY – Each question must be individually asked and answered for each proposed Insured.

A) The proposed Insured is a citizen of ☐ USA ☐ Other Country _____ Type of VISA_____

B) How many years has the proposed Insured resided in the USA?_____

C) Does any proposed Insured travel outside the USA? ☐ Yes ☐ No

If yes, provide details: include name of proposed Insured, destination, number of trips, duration of each trip, purpose of trip, plans for the next year._____

_____

SECTION 20. DRIVING AND PUBLIC RECORDS –Each question must be individually asked and answered for each proposed Insured.

A) Has any proposed Insured had their driver's license suspended, restricted, revoked, or been cited for a moving violation in the last 5 years? ☐ Yes ☐ No If yes, include name of proposed Insured and give reason:

_____

_____

B) Has any proposed Insured in the last ten years been convicted of a misdemeanor (other than a minor traffic violation) or felony? ☐ Yes ☐ No If yes, include name of proposed Insured and give reason:

_____

_____

SECTION 21. SPECIAL ACTIVITIES – Each question must be individually asked and answered for each proposed Insured.

A) Except as a passenger on a regularly scheduled flight, has any proposed Insured flown within the past 2 years, or does any proposed Insured have plans to fly in the future? If yes, complete the Avocation and Aviation Questionnaire. ☐ Yes ☐ No

B) In the past 2 years has any proposed Insured participated in organized racing (automobile, motorcycle, or boat), underwater or sky diving, hang gliding, canyoneering, mountain or rock climbing? If yes, complete the Avocation and Aviation Questionnaire. ☐ Yes ☐ No

SECTION 22. TRANSFER AUTHORIZATION–TO BE COMPLETED BY APPLICANT/OWNER (only for IUL)

Transfer Authorization:

Your policy applied for, if issued, will automatically receive transfer privileges, unless declined below. These privileges only allow the Owner and agent of record to change premium allocations and transfer between the Basic Interest Account and the Index Account. Transfers are subject to the restrictions/guidelines outlined in the Statement of Understanding.

Western Reserve Life Assurance Co. of Ohio will not be liable for complying with transfer instructions it reasonably believes to be authentic, nor for any loss, damage, costs or expense in acting on such instructions, and Policy Owners will bear the risk of any such loss. Western Reserve Life Assurance Co. of Ohio will employ reasonable procedures to confirm that transfer instructions are genuine. If Western Reserve Life Assurance Co. of Ohio does not employ such procedures, it may be liable for losses due to unauthorized or fraudulent instructions. These procedures include but are not limited to requiring forms of personal identification prior to acting upon such transfer instruction, providing written confirmation of such transactions to the Owner and/or tape recording of telephone transfer request instructions received.

☐ The agent does **not** have authority to make transfers or change payment allocations on my behalf.

SECTION 23. OTHER INSURANCE–TO BE COMPLETED BY THE AGENT

A) Will the policy applied for discontinue, replace or change any existing life insurance policy or annuity? ☐ Yes ☐ No

B) If mandated by your state, did you present, read and leave a copy of the Replacement Notice with the Applicant/Owner at time of application? ☐ Yes ☐ No

(In some states the Replacement Notice must be completed and sent in with the application whether or not the Applicant/Owner intends to replace existing coverage.)

C) Did you present and leave the Applicant/Owner approved sales material? ☐ Yes ☐ No

SECTION 24. ILLUSTRATION CERTIFICATION (if applicable) **The box below MUST be checked if a signed illustration of the policy applied for is NOT enclosed with this application.**

☐ The Applicant/Owner and the Licensed Agent certify that they have each read and agree with their respective statements below regarding the policy applied for:

Applicant's/Owner's statement: By signing this application, I, the Applicant/Owner acknowledge that I have NOT received an illustration of the policy applied for and understand that an illustration of the policy as issued will be provided no later than the policy delivery date. **Licensed Agent's statement:** By signing this application, I, the Licensed Agent certify that I have NOT provided an illustration of the policy as applied for. However, I will provide an illustration conforming to the policy as issued upon or prior to delivery of the policy.

SECTION 25. TAXPAYER IDENTIFICATION CERTIFICATION

Under current federal tax laws, the Company is required to obtain your Taxpayer Identification Number (e.g., a social security or employer identification number, or "TIN") and certification that you are not subject to backup withholding. Please review the following certification and sign accordingly.

Under penalties of perjury, I certify that (1) the TIN listed in this application is my correct TIN; (2) I have not been notified that I am subject to backup withholding or I am not subject to backup withholding because I am an exempt recipient; and (3) I am a U.S. Person (U.S. citizen/legal resident). If not a U.S. Person, I have completed the appropriate Form W-8BEN. The IRS does not require your consent to any provision of this form other than this certification.

Signature of Owner _____ **Date** _____

SECTION 26. AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Each of the undersigned hereby certifies and represents as follows: The statements and answers given on this application are true and correct. I acknowledge and agree (A) that this application and any amendments shall be the basis for any insurance issued; (B) that the agent does not have the authority to waive any question on this application, to decide if insurance will be issued, or to modify any term or provision of any insurance which may be issued based on this application, only a writing signed by an officer of the Company can change the terms of this application or the terms of any insurance issued by the Company; (C) except as provided in the Conditional Receipt, if issued with the same proposed Insured(s) as on this application, no policy applied for shall take effect until after all of the following conditions have been met: 1) the minimum initial premium must be received by the Company; 2) the proposed Owner must have personally received and accepted the policy during the lifetime of all proposed Insured(s) and while all proposed Insured(s) are in good health; and 3) on the date of the later of either 1) or 2) above, all of the statements and answers given in this application must be true and complete, and the insurance will not take effect if the facts have changed. Unless otherwise stated the undersigned applicant is the premium payor and Owner of the policy applied for.

I authorize MIB Group, Inc. and its members or affiliates, my employer or former employer, any consumer reporting agency or governmental agency, medical provider, or any insurer or reinsurer to provide medical or personal information about me that is reasonably required for the purposes stated in this authorization to Western Reserve Life Assurance Co. of Ohio, its administrators, representatives or its reinsurers. I understand the information obtained by use of the authorization will be used by Western Reserve Life Assurance Co. of Ohio to determine eligibility for insurance, and eligibility for benefits under an existing policy. Any information obtained will not be released by Western Reserve Life Assurance Co. of Ohio to any person or organization except to reinsurers, MIB Group, Inc. and its members or affiliates, or other persons or organizations performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may authorize. This authorization will expire 30 months (24 months in Iowa, Kentucky, New Mexico and Wyoming) from the date signed. A copy of this authorization shall be as valid as the original. Either my authorized representative or I may receive a copy of this authorization upon request.

The Company shall have sixty days from the date hereof within which to consider and act on this application and if within such period a policy has not been received by the applicant or if notice of approval or rejection has not been given, then this application shall be deemed to have been declined by the Company.

I acknowledge receipt of the (1) Notice to Persons Applying for Insurance Regarding Investigative Report, (2) MIB Group, Inc. Pre-Notification, and (3) Notice of Insurance Information Practices.

I understand that any omissions or misstatements in this application could cause an otherwise valid claim to be denied under any insurance issued from this application.

I also understand that I will not receive any insurance coverage for any money paid with this application unless a policy is issued except in accordance with the terms of the Conditional Receipt.

Signed at _____ (city) _____ (state) on MM – DD – YYYY (date)

_____ Signature of proposed Primary Insured/Owner (Child over age 15 must sign)	_____ Print Agent Name
_____ Signature of parent or legal guardian for Insured(s) 15 and under	_____ Agent #
_____ Signature of proposed Additional Insured	
_____ Signature of Applicant/Owner if other than the proposed Primary Insured (If business insurance, show title of officer and name of firm. If trust, show trustee's name)	_____ Signature of Agent/Licensed Rep.
	_____ Signature of Split Agent/Licensed Rep.

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FRAUD WARNING

The following state(s) and U.S. territories require that insurance applicants acknowledge a fraud warning statement. Please refer to the fraud warning statement for your state or U.S. territory as indicated below.

For applicants in ARKANSAS, LOUISIANA and WEST VIRGINIA

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Applicant's Signature Date

For applicants in COLORADO

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Applicant's Signature Date

For applicants in DISTRICT OF COLUMBIA

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Applicant's Signature Date

For applicants in FLORIDA

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Applicant's Signature Date

For applicants in KENTUCKY

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Applicant's Signature Date

For applicants in MAINE and TENNESSEE

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Applicant's Signature Date

For applicants in NEW JERSEY

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Applicant's Signature Date

For applicants in NEW MEXICO

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Applicant's Signature Date

For applicants in OHIO

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Applicant's Signature Date

For applicants in OKLAHOMA

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Applicant's Signature Date

For applicants in PENNSYLVANIA

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Applicant's Signature Date

For applicants in PUERTO RICO

Any person who knowingly, and with the intention to defraud, includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony, and if found guilty, shall be punished for each violation with a fine of no less than five thousand dollars ($5000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Applicant's Signature Date

For applicants in VIRGINIA and WASHINGTON

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Applicant's Signature Date

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CONDITIONAL RECEIPT

(Detach and leave with applicant only if money is submitted with application. **If within the past 12 months any proposed Insured has been treated for or experienced heart trouble, stroke or cancer, no payment may be accepted with the application.** Do not accept money unless all required signatures below are obtained.)

PLEASE READ THIS CAREFULLY

No coverage will become effective prior to the delivery of the policy applied for unless and until all conditions of this receipt have been fulfilled exactly. No agent or field representative is authorized to waive or modify any of the provisions of the conditional receipt.

Make all checks payable to the Company. Do not make checks payable to the agent or leave the payee blank or you may jeopardize the insurance for which you have applied.

Received from _____, the sum of $_____ for the insurance application dated _____, with _____ as the proposed Insured(s). The policy you applied for will not become effective unless and until a policy contract is delivered to you and all other conditions of coverage are met. However, subject to the conditions and limitations of this Receipt, conditional insurance under the terms of the policy applied for may become effective as of the later of (1) the date of application and (2) the date of the last medical examination, tests, and other screenings required by the Company, if any (the "Effective Date"). Such conditional insurance will take effect as of the Effective Date, so long as all of the following requirements are met:

1. Each person proposed to be Insured is found to have been insurable as of the Effective Date, exactly as applied for in accordance with the Company's underwriting rules and standards, without any modifications as to plan, amount, or premium rate;
2. As of the Effective Date, all statements and answers given in the application must be true;
3. The payment made with the application must not be less than the full initial premium for the mode of payment chosen in the application, must be received at our Administrative Office within the lifetime of the proposed Insured to whom the conditional coverage would apply and, if in the form of check or draft, must be honored for payment;
4. All medical examinations, tests, and other screenings required of the proposed Insured by the Company are completed and the results received at our Administrative Office within 60 days of the date the application was completed; and
5. All parts of the application, any supplemental application, questionnaires, addendum and/or amendment to the application are signed and received at our Administrative Office.

Any conditional coverage provided by this Receipt will terminate on the earliest of: (a) 60 days from the date the application was signed; (b) the date the Company either mails notice to the applicant of the rejection of the application and/or mails a refund of any amounts paid with the application; (c) when the insurance applied for goes into effect under the terms of the policy applied for; or (d) the date the Company offers to provide insurance on terms that differ from the insurance for which you have applied.

If one or more of this Receipt's conditions have not been met exactly, or if a proposed Insured dies by suicide, the Company will not be liable except to return any payment made with the application.

If the Company does not approve and accept the application for insurance within 60 days of the date you signed the application, the application will be deemed to be rejected by the Company and there will be no conditional insurance coverage. In that case, the Company's liability will be limited to returning any payment(s) you have made upon return of this Receipt to the Company.

The aggregate amount of conditional coverage provided under this Receipt, if any, and any other conditional receipt issued by the Company shall be limited to the lesser of the amount(s) applied for or $500,000 of life insurance. There is no conditional coverage for riders or any additional benefits, if any, for which you have applied.

Authorization (Signatures Required)
I certify that I have read and reviewed the Conditional Receipt and the Authorization to Obtain and Disclose Information in the application. The terms and conditions of the Conditional Receipt have been explained to me fully by the agent and I understand them.

Dated at _____ on _____ _____

City, State | Date | Signature of Agent or Authorized Company Rep

_____ _____

Signature of proposed Insured | Signature of Applicant (if other than proposed Insured)

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NOTICES

DETACH AND LEAVE THIS PAGE WITH APPLICANT

NOTICE TO PERSONS APPLYING FOR INSURANCE REGARDING INVESTIGATIVE REPORT

To proposed Insured: In connection with this application, an investigative consumer report may be prepared about you. Such reports are part of the process of evaluating risks for life and health insurance. Typically, this report will contain information about your character, general reputation, personal characteristics and mode of living. The information in the report may be obtained by talking with you or members of your family, business associates, financial sources, neighbors, and others you know. You may ask to be interviewed in connection with the preparation of any such report. Also, we may have the report updated if you apply for more coverage.

Upon your written request, we will let you know whether a report was prepared and we will give you the name, address, and telephone number of the agency preparing the report. By contacting that agency and providing proper identification, you may obtain a copy of the report.

MIB GROUP, INC. (MIB) PRE-NOTIFICATION

To proposed Insured and other persons proposed to be insured, if any. Information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report on this information to MIB Group, Inc., a non-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB may, upon request, supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: Post Office Box 105, Essex Station, Boston, Massachusetts 02122; and telephone number is 866-692-6901 (TTY 866-346-3642 for hearing impaired).

NOTICE OF INSURANCE INFORMATION PRACTICES

To proposed Insured: Personal information may be collected from persons other than the individual(s) proposed for coverage. Such information as well as other personal or privileged information subsequently collected by us or our agent may in certain circumstances be disclosed to third parties without authorization. Upon request, you have the right to access your personal information and ask for corrections. You may obtain a complete description of our Information Practices by writing to Western Reserve Life Assurance Co. of Ohio, Attn: Director of Underwriting, 4333 Edgewood Road NE, Cedar Rapids, Iowa 52499.

PLEASE PROVIDE A COPY OF THIS NOTICE TO THE PROPOSED INSURED IF NOT A HOUSEHOLD MEMBER.

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Additional Insured Supplement

SECTION 1. PROPOSED ADDITIONAL INSURED **SPECIFIED AMOUNT $_____**

We will allow the AIR death benefit recipient to be a choice of: ☐ Owner ☐ Primary Insured ☐ Same beneficiary as the base policy

1. Last Name	First Name	M.I.
2. Address (Cannot be a P.O. Box)	Apt#	City

State	Zip Code	3. Years at Address	4. Home Phone ( )	5. Driver License Number	State
6. Sex ☐ Male ☐ Female	7. Date of Birth M M - D D - Y Y Y Y	8. Age	9. Place of Birth – State/Country	10. Social Security Number	
11. Height ft in	12. Weight lbs	13. Marital Status	14. Relationship to proposed Primary Insured		

15. Employer's Name, Address and Phone Number

16. Occupation & Duties # Years

17. Have you used **TOBACCO** or any other product containing **NICOTINE** in the last 5 years? ☐ Yes ☐ No Date last used_____

18. Rate Class Quoted: ☐ Preferred Elite ☐ Preferred Plus ☐ Preferred ☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco ☐ Juvenile

SECTION 2. PROPOSED ADDITIONAL INSURED **SPECIFIED AMOUNT $_____**

We will allow the AIR death benefit recipient to be a choice of: ☐ Owner ☐ Primary Insured ☐ Same beneficiary as the base policy

1. Last Name	First Name	M.I.
2. Address (Cannot be a P.O. Box)	Apt#	City

State	Zip Code	3. Years at Address	4. Home Phone ( )	5. Driver License Number	State
6. Sex ☐ Male ☐ Female	7. Date of Birth M M - D D - Y Y Y Y	8. Age	9. Place of Birth – State/Country	10. Social Security Number	
11. Height ft in	12. Weight lbs	13. Marital Status	14. Relationship to proposed Primary Insured		

15. Employer's Name, Address and Phone Number

16. Occupation & Duties # Years

17. Have you used **TOBACCO** or any other product containing **NICOTINE** in the last 5 years? ☐ Yes ☐ No Date last used_____

18. Rate Class Quoted: ☐ Preferred Elite ☐ Preferred Plus ☐ Preferred ☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco ☐ Juvenile

SECTION 3. PROPOSED ADDITIONAL INSURED **SPECIFIED AMOUNT $_____**

We will allow the AIR death benefit recipient to be a choice of: ☐ Owner ☐ Primary Insured ☐ Same beneficiary as the base policy

1. Last Name	First Name	M.I.
2. Address (Cannot be a P.O. Box)	Apt#	City

State	Zip Code	3. Years at Address	4. Home Phone ( )	5. Driver License Number	State
6. Sex ☐ Male ☐ Female	7. Date of Birth M M - D D - Y Y Y Y	8. Age	9. Place of Birth – State/Country	10. Social Security Number	
11. Height ft in	12. Weight lbs	13. Marital Status	14. Relationship to proposed Primary Insured		

15. Employer's Name, Address and Phone Number

16. Occupation & Duties # Years

17. Have you used **TOBACCO** or any other product containing **NICOTINE** in the last 5 years? ☐ Yes ☐ No Date last used_____

18. Rate Class Quoted: ☐ Preferred Elite ☐ Preferred Plus ☐ Preferred ☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco ☐ Juvenile

SECTION 4. PROPOSED ADDITIONAL INSURED

SPECIFIED AMOUNT $_____

We will allow the AIR death benefit recipient to be a choice of: ☐ Owner ☐ Primary Insured ☐ Same beneficiary as the base policy

1. Last Name	First Name	M.I.

2. Address (Cannot be a P.O. Box)	Apt#	City

State	Zip Code	3. Years at Address	4. Home Phone ( )	5. Driver License Number	State

6. Sex ☐ Male ☐ Female	7. Date of Birth M M - D D - Y Y Y Y	8. Age	9. Place of Birth – State/Country	10. Social Security Number

11. Height ft in	12. Weight lbs	13. Marital Status	14. Relationship to proposed Primary Insured

15. Employer's Name, Address and Phone Number

16. Occupation & Duties	# Years

17. Have you used **TOBACCO** or any other product containing **NICOTINE** in the last 5 years? ☐ Yes ☐ No Date last used _____

18. Rate Class Quoted: ☐ Preferred Elite ☐ Preferred Plus ☐ Preferred ☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco ☐ Juvenile

SECTION 5. DECLARATIONS

I (We) represent that all statements and answers made in this supplement are full, complete and true to the best of my (our) knowledge and belief. It is agreed that this statement shall be made part of the application, and is subject to all terms and conditions contained in the application.

Signed at _____ (city) _____ (state) on M M - D D - Y Y Y Y (date)

sec. 1 _____
Signature of proposed Additional Insured
(Child over 15 must sign)

sec. 3 _____
Signature of proposed Additional Insured
(Child over 15 must sign)

sec. 2 _____
Signature of proposed Additional Insured
(Child over 15 must sign)

sec. 4 _____
Signature of proposed Additional Insured
(Child over 15 must sign)

_____
Signature of Parent or Legal Guardian for Insured(s) 15 and under

_____
Signature of Applicant/Owner, if other than the proposed Primary Insured (If business insurance, show title of officer and name of firm. If trust, show trustee's name)

_____
Witness (Registered Representative)

AGENT'S REPORT
(all sections must be completed)

1. **Type of Sale** (check only one box)
   ☐ Personal/Family
   ☐ Business Planning
   ☐ Estate Planning

   Supplemental Purpose of Policy (check only one box)

Business	Personal/Family
☐ Key Employee	☐ Mortgage
☐ Executive Bonus	☐ Retirement
☐ Deferred Compensation	☐ Education
☐ Split Dollar	☐ Income to Family
☐ Buy/Sell - Is Partner applying for similar amount? ☐ Yes ☐ No	☐ Cash Accumulation
Name of Partner _____	Estate Planning
☐ Other _____	☐ Estate Liquidity
	☐ Wealth Replacement

2. Was this plan sold, presented or illustrated as a single employer welfare benefit plan as defined under IRC Section 419?
   ☐ Yes ☐ No
   If "Yes", have you completed and attached the required Disclosure, Acknowledgment and Release Form? ☐ Yes ☐ No

3. a) How long have you known the proposed Insured?
   _____
   b) Relationship to proposed Insured: _____
   _____
   c) Are you financially responsible for the proposed Insured?
   ☐ Yes ☐ No

4. Is the proposed Insured or Owner a licensed Representative of any Broker/Dealer? If yes, name and address of Broker/Dealer _____
   _____

5. Is the proposed Insured or Owner related to any affiliated Broker/Dealer officer or employee? ☐ Yes ☐ No
   If yes, name and address of Broker/Dealer _____
   _____

6. Did you give the "Notice of Information Practices" to the proposed Insured? ☐ Yes ☐ No

7. Are you submitting or do you plan to submit another application on any proposed Insured listed to WRL or any other company?
   ☐ Yes ☐ No
   Company Name _____
   Face amount $ _____
   Total face amount to be placed with all companies $ _____

8. Medical Examination
   Are you arranging for the Medical Requirements?
   ☐ Yes Paramedical Service used: _____
   ☐ No Request Western Reserve Life Assurance Co. of Ohio order medical requirements.

9. Did you ask all questions in the physical presence of the proposed Insured? ☐ Yes ☐ No

10. Are you aware of anything about the health, habits, hazardous sports, environment or mode of living, which may affect the insurability of any person proposed for insurance?
    ☐ Yes ☐ No

11. Financial Information of Applicant/Owner **if other** than the proposed Insured:
    Gross Income Current Year: $_____.____
    Current Net Worth: $_____.____

12. Did you comply with all requirements relative to obtaining Informed Consent for HIV and AIDS testing? ☐ Yes ☐ No

13. Identification Verification
    Identification was viewed during face to face sale? ☐ Yes ☐ No
    Type of Government issued photo ID _____
    Issuer of Identification Document _____
    Number_____ Expiration Date _____

14. Is the Agent or Split Agent also the Owner, Applicant or Payor?
    ☐ Yes ☐ No

15. Writing Agent Name _____
    Agent No. _____
    Agent's Telephone Number _____
    Agent's Fax Number _____
    Agent's E-Mail _____
    Percent of Agent's Split _____
    Split Agent Name _____
    Agent No._____Percent of Agent's Split _____

16. Was money taken with the application?
    ☐ Yes ☐ No
    If "yes", was the Conditional Receipt completed and given to the applicant? ☐ Yes ☐ No

17. If proposed Insured is a juvenile (ages 0 through 15):
    (a) Did you personally see child? ☐ Yes ☐ No
    (b) Does child live with parents? ☐ Yes ☐ No
    (If "No," explain) _____
    _____
    (c) Life insurance in force on father's life? ☐ Yes ☐ No
    If yes, list amount _____
    Life insurance in force on mother's life? ☐ Yes ☐ No
    If yes, list amount _____
    (d) Life insurance applied for or in force on brothers and sisters? ☐ Yes ☐ No
    If yes, list amount(s) _____
    _____

I submit this application assuming full responsibility for delivery of any coverage issued and for immediate transmittal to the Company of the first premium when collected. I certify that I reviewed the photo identification of the person(s) seeking to open this policy and verified that person seeking to open this policy is the same person in the documents reviewed. I understand that misrepresentations in connection with this and other certifications in the Company's application documents may result in disciplinary action, termination, civil action or prosecution for violation of state or federal criminal laws.

$_____ has been paid by the Applicant with this application.

_____ Signature of Writing Agent

_____ Date

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PAYOR'S CHECK-O-MATIC PREMIUM PAYMENT PLAN

Authorization to Insurance Company

The Premium Payor hereby authorizes Western Reserve Life Assurance Co. of Ohio to debit his/her account or accounts by means of check or draft drawn or other order made whether by electronic or paper means at the below named financial institution for premiums that may become due under the policy as a result of this application. This authorization is to remain in effect until written notice of revocation is received at the Administrative Office of the Company or until the Check-O-Matic Premium Payment Plan is terminated in a manner provided below. I (We) expressly agree to all conditions applicable to the Check-O-Matic Premium Payment Plan including those appearing below.

Authorization to Financial Institution

As a convenience to me, I hereby request and authorize you to pay and charge to my account checks, drafts and other order's whether by electronic or paper means, with such debits made to my account and drawn or directed by Western Reserve Life Assurance Co. of Ohio to its own order, provided there are sufficient collected funds in said account to pay the same upon presentation. Until you receive written cancellation of this authorization by me (or either of us), you are fully protected when you honor any of those orders. You may, however, discontinue this arrangement by giving 30 days written notice to me (or either of us) and the insurance company. Your treatment of and your rights regarding those orders, shall be the same as if I signed or initiated them. If any of those orders are not honored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability if insurance is forfeited as a result. Notice of charge for debit is hereby waived.

Initial Payment (Must Check One Box)

☐ CHECK: Check this box if you are attaching a check for the initial modal premium. The check will be deposited upon receipt of the application by the Company.

☐ AUTOMATIC WITHDRAWAL: Check this box to have the initial modal premium withdrawn from the account listed below. By checking this box, I/we agree that I/we want an amount sufficient to pay the initial premium due for the insurance policy withdrawn from the account. This initial premium amount may not equal the amount reflected below. I/we further understand that no insurance will be provided except under the terms of a conditional receipt which may be given at the time the application is taken, and then only if and when all conditions and requirements of the conditional receipt have been satisfied.

Initial premium will be withdrawn upon receipt of the application by the Company and not on the day of the future recurring monthly payment stated below.

Account Information

TAPE VOIDED CHECK HERE

If not attaching void check or if withdrawing from Savings Account, complete the following information

Bank Name, Office or Branch

Payor Name(s)

Check one: ☐ Checking ☐ Savings

Transit Routing Number

Account Number

Complete the Following Information for Future Recurring Payments

Premium to Withdraw	☐ Withdraw on day of the month matching the policy's effective date (this will be elected if no box is checked)
$ _____	☐ Withdraw on a different day of the month; choose a day between 1 and 28 _____

Signature

Payor Signature(s) – as on financial institution's records. A copy is as valid as the original.

X _____ **Date:** _____

Conditions Applicable to Check-O-Matic Premium Payment Plan

No check, draft or any other orders, either by electronic or paper means, shall constitute payment until the Company actually receives payment thereof within the period provided in the policy.

The Check-O-Matic Premium Payment Plan may be terminated by either party by giving written notice to the other.

The Check-O-Matic Premium Payment Plan does not in any manner amend or alter the terms and provisions of any policy, contract or agreement except as may be specifically stated in a policy endorsement or properly executed contract amendment.

For changes or questions call: Toll-free 1-800-851-9777

Or Write: Western Reserve Life Assurance Co. of Ohio, 4333 Edgewood Road NE, Cedar Rapids, Iowa 52499